

Patient Medical History

Date of last physical exam: _____ Physician Name: _____

Address: _____

PAST HISTORY (Personal and Allergies):

Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Overuse	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (other than medications)	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Other Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Kidney or Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Lung Infections	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>				Measles	<input type="checkbox"/>	<input type="checkbox"/>
						Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>
						Mumps	<input type="checkbox"/>	<input type="checkbox"/>
						Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>
						Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
						Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>
						Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
						Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
						Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
						Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>

PERSONAL HABITS:

- 1) Have you ever smoked? Yes No Have you used chewing tobacco? Yes No # of yrs _____
 If yes, are you are regular smoker now? Yes No If No, when did you quit? _____
- 2) Do you regularly drink alcohol: Yes No If yes, how often: _____
- 3) Have you ever used any of the following: Marijuana LSD Heroin Cocaine Speed Other _____

OPERATIONS: List and indicate approximate year.

SERIOUS INJURIES:

List injuries and give approximate dates.

HOSPITALIZATIONS: (Other than operations)

List reasons and approximate dates

DIAGNOSTIC TESTS/EXAMS:

LAST TEST/EXAM	DATE	LOCATION/PROVIDER
EYE EXAM:	_____	_____
FOOT EXAM:	_____	_____
PAP SMEAR:	_____	_____
MAMMOGRAM:	_____	_____

IMMUNIZATIONS: (Please give date) Hepatitis B _____ Flu _____ Polio _____

Typhoid _____ Smallpox _____ Tetanus _____ Pneumococcal _____ Chicken Pox _____

FAMILY HISTORY	Circle Sex		IF LIVING		IF DECEASED	
			AGE	HEALTH	AGE AT DEATH	CAUSE
Father						
Mother						
Brothers/Sisters	M	F				
	M	F				
	M	F				
Husband/Wife						
Sons/Daughters	M	F				
	M	F				
	M	F				

Check if any blood relative has or had any of the following and enter their relationship:

Yes No		Relationship to you	Yes No		Relationship to you
Arthritis	<input type="checkbox"/> <input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	_____
Asthma	<input type="checkbox"/> <input type="checkbox"/>	_____	Intestinal Polyps	<input type="checkbox"/> <input type="checkbox"/>	_____
Bleeding Tendency	<input type="checkbox"/> <input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/> <input type="checkbox"/>	_____
Cancer	<input type="checkbox"/> <input type="checkbox"/>	_____	Leukemia	<input type="checkbox"/> <input type="checkbox"/>	_____
Colitis	<input type="checkbox"/> <input type="checkbox"/>	_____	Migraine	<input type="checkbox"/> <input type="checkbox"/>	_____
Congenital Heart Disease	<input type="checkbox"/> <input type="checkbox"/>	_____	Nervous Breakdown	<input type="checkbox"/> <input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	_____	Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/> <input type="checkbox"/>	_____	Sickle Cell Anemia	<input type="checkbox"/> <input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/> <input type="checkbox"/>	_____	Stomach Ulcers	<input type="checkbox"/> <input type="checkbox"/>	_____
Goiter	<input type="checkbox"/> <input type="checkbox"/>	_____	Stroke	<input type="checkbox"/> <input type="checkbox"/>	_____
Gout	<input type="checkbox"/> <input type="checkbox"/>	_____	Suicide	<input type="checkbox"/> <input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/> <input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/> <input type="checkbox"/>	_____	Other	<input type="checkbox"/> <input type="checkbox"/>	_____

MEDICATIONS:

<input type="checkbox"/> Asthma Wheezing Medicine	<input type="checkbox"/> Sleeping Pills/Tranquilizers
<input type="checkbox"/> Aspirin, Bufferin, Anacin, Tylenol or Similar Products	<input type="checkbox"/> Thyroid Medicine
<input type="checkbox"/> Blood Pressure Pills	<input type="checkbox"/> Stomach/Digestive Medicine
<input type="checkbox"/> Cortisone, Prednisone	<input type="checkbox"/> Weight-Reducing Pills
<input type="checkbox"/> Cough Medicine	<input type="checkbox"/> Blood Thinners or Coumadin
<input type="checkbox"/> Digitalis or Heart Medicine	<input type="checkbox"/> Dilantin or Seizure Medications
<input type="checkbox"/> Hormones	<input type="checkbox"/> Water Pills or Diuretics
<input type="checkbox"/> Insulin or Diabetic Pills	<input type="checkbox"/> Antibiotics
<input type="checkbox"/> Anemia Medications	<input type="checkbox"/> Phenobarbital/Barbiturates
<input type="checkbox"/> Laxatives	<input type="checkbox"/> Vitamins
	<input type="checkbox"/> Other Prescription or Over the Counter Drugs

